Employee Benefits Handbook

City of Locust Grove

Plan Year September 1, 2013 thru November 30, 2014

This handbook includes information on the following:

Medical Benefits | Health **Reimbursement Arrangement** | **Dental Benefits**
Life Insurance | Disability Insurance | **COBRA Notification** | Contact Information

CONTENTS

This booklet is a summary only. Please refer to each plan's certificate of coverage / plan document for complete description of all benefits and exclusions. If there is any difference between the informatic provided in this booklet and any certificate of coverage / plan document, the certificate of coverage / pla document will govern. Copies of all certificates of coverage / plan documents are available in the Huma Resources department. In the event that some information changes, you will receive notice about th changes prior to the annual Open Enrollment. If you are a new employee, this information will help you t understand the benefit options available to you. If you're already covered by any of the benefit plans, yo may refer to this booklet throughout the year as you use your benefits. This booklet also provides informatio regarding your COBRA rights and responsibilities.

ELIGIBILITY

Newly hired full-time employees are eligible for benefits on the first day of the month following 3 days of service. Spouses and dependent children of the employee are also eligible to participate in ou benefit plans. Dependent children include natural children, legally adopted children, stepchildren, an children for whom the employee has been appointed guardian. Federal law requires all health plans to repor social security numbers for employees and covered dependents. Please make sure to have all necessar names, birthdates and social security numbers available for your enrollment.

CHANGES

Pre-Tax Deduction of Premiums (Section 125 Plan) - Health insurance premiums are deducted (if you have elected deductions) from your pay on a pre-tax basis (exempt from FICA, Federal and State tax) which in turn provides significant cost savings. This will continue and does not require any action on your part unless you desire to make changes. You will be able to make changes on any of your elections during the open enrollment period. Your selections cannot be changed until next year unless the revocation and new election are due to and consistent with a valid status change (e.g., marriage, divorce, death of a spouse or child, birth or adoption of a child or change of employment of your spouse as detailed in the Section 125 Regulations). ***If you have a status change during the year you must notify Human Resources within 30 days. Any request to make changes after 30 days will not be allowed until the next annual open enrollment.*** Please contact the City at (770) 957-5043 if you have any questions regarding the open enrollment period or changes.

MESSAGE FROM MAYOR PRICE

To: All Full Time Employees
From: Robert Price
Subject: Employee Benefits

The City of Locust Grove appreciates very much the hard work and dedication of all our employees and we recognize that a quality, comprehensive benefits package is a critical component in retaining skilled and seasoned employees as well as recruiting new talent when needed.

This handbook is provided to you as a quick reference tool for information regarding many features of the various benefit plans offered to our employees. You will find answers to many of your benefit questions in this handbook as well as contact information for a variety of resources.

On behalf of all council members, we thank you for all of your hard work!

Robert Price
Mayor
City of Locust Grove

LOCUST GROVE CITY COUNCIL

Vernon Ashe
Councilman
2012 - 2016

Keith Boone
Councilman
2010 - 2014

Sam Rosser
Councilman
2010 - 2014

Otis Hammock
Councilman
2012 - 2016

Frances Ward
Councilwoman
2012 - 2016

Sammy Brown
Councilman
2012 - 2016

COVENTRY

SIDE by SIDE MEDICAL COMPARISON

The City of Locust Grove offers two Coventry Health Care of Georgia health plan options, a $3,50(deductible plan and a $5,000 deductible plan. You will automatically be enrolled in a Healtl Reimbursement Arrangement (HRA) that the City has established to help offset the increase in the annua deductible. The HRA will reimburse you the last $1,000 (includes specialist, ER, urgent care and Rx) of th deductible for the $3,500 Choice Plan or the last $2,500 (inpatient and outpatient services) of the deductibl for the $5,000 Premier Plus Plan. Please see page 7 for a detailed explanation of the Health Reimbursemen Arrangement.

IN-NETWORK	$3,500 Choice Plan	$5,000 Premier Plus Pla
Individual Annual Deductible	$3,500	$5,000
Health Reimbursement Arrangement (HRA)*	- $1,000	- $2,500
Net Annual Deductible	$2,500	$2,500
Individual Out-of-Pocket Maximum (excludes deductible/copays)	N/A	N/A
Member Co-Insurance	Member Pays 0% Plan Pays 100%	Member Pays 0% Plan Pays 100%
Primary Care Physician Copay	$35	$30
Specialist Physician Copay	Deductible + $50	$60
Preventive Health Services*	No Cost to the Member	
Urgent Care Copay	Deductible + $75	$75
Emergency Room Copay (waived if admitted)	Deductible + $150	$200
Inpatient Surgery	Deductible	Deductible
Outpatient Surgery	Deductible	$100 Copay + Deductible

*Preventive Health Services are defined in the Patient Protection & Affordability Care Act and do not have any member cost sharing responsibility for In-Network services.

OUT-OF-NETWORK	$3,500 Choice Plan	$5,000 Premier Plus Pla
Individual Annual Deductible	$3,500	$5,000
Health Reimbursement Arrangement (HRA)*	- $1,000	- $2,500
Net Annual Deductible	$2,500	$2,500
Individual Out-of-Pocket Maximum (excludes deductible)	$24,000	$8,000
Member Co-Insurance	Member pays 60% Plan pays 40%	Member pays 70% Plan pays 30%
PRESCRIPTION DRUG CO-PAYMENTS	**$3,500 Choice Plan**	**$5,000 Premier Plus Pla**
Your copayment for up to a 31 day supply of Prescription Drugs *other than* Self-Administered Injectable Drugs:		
Deductible - Tier's 2, 3, and 4 only	$3,500	N/A
Prescription Drug - Tier 1A - Deductible requirements do not apply	$3	$3
Prescription Drug - Tier 1 - Deductible requirements do not apply	$15	$15
Prescription Drug - Tier 2	$35	$35
Prescription Drug - Tier 3	$65	$65
Self-Administered Injectable or Specialty Pharmacy Tier 4 Prescription Drugs	$100	$100
Prescription Drugs on the Mail Order Drug List may be dispensed with the applicable Mail Order Copayment for a 93 day supply.		
Mail Order Prescription Drug - Tier 1 or 1A	$6 / $30	$6 / $30
Mail Order Prescription Drug - Tier 2	$87.50	$87.50
Mail Order Prescription Drug - Tier 3	$195	$195
Mail Order is not available for Tier 4 Prescription Drugs or Specialty Medications		

* The HRA amount is combined between in and out-of-network

EMPLOYEE DEDUCTIONS

Bi-Weekly (26 / year)

MEMBERS COVERED	$3,500 Choice Plan	$5,000 Premier Plus Pla
Employee Only	$ 22.84	$ 62.89
Employee + Spouse	$188.73	$272.85
Employee + Child(ren)	$155.30	$233.41
Employee + Family	$235.80	$357.98

$3,500 CHOICE PLAN BENEFIT SUMMARY

COVENTRY

BENEFITS	MEMBER PAYS	
	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE	Individual: $3,500 Family: $7,000	Individual: $7,000 Family: $14,000
ANNUAL OUT-OF-POCKET MAXIMUM	Individual: NA Family: NA	Individual: $10,000 Family: $20,000
PRIMARY CARE PHYSICIAN (PCP) SERVICES - When performed and billed in a physician's office.		
Office Visits	$35 Copay	Deductible + 40%
Allergy Testing, Treatment and Injections	$35 Copay	Deductible + 40%
Chemotherapy and Radiation	$35 Copay	Deductible + 40%
Family Planning	$35 Copay	Deductible + 40%
Laboratory Services - *When specimen is drawn in physician's office*	$35 Copay	Deductible + 40%
Radiology - *When test is performed in physician's office*	$35 Copay	Deductible + 40%
Physician services are limited to one Copay per Member, per provider, per date of service and per place of service. Copay applies to every visit to the office.		
SPECIALIST PHYSICIAN SERVICES - When performed and billed in a physician's office.		
Office Visits	Deductible, then $50	Deductible + 40%
Allergy Testing, Treatment and Injections	Deductible, then $50	Deductible + 40%
Chemotherapy and Radiation	Deductible, then $50	Deductible + 40%
Family Planning	Deductible, then $50	Deductible + 40%
Laboratory Services - *When specimen is drawn in physician's office*	Deductible, then $50	Deductible + 40%
Radiology - *When test is performed in physician's office*	Deductible, then $50	Deductible + 40%
Physician services are limited to one Copay per Member, per provider, per date of service and per place of service. Copay applies to every visit to the office.		
PREVENTIVE HEALTH SERVICES		
Annual Adult Physical	No cost to the member	Deductible + 40%
Annual Well-Woman exam (*including annual Pap smear*)	No cost to the member	Deductible + 40%
Immunizations and Vaccines	No cost to the member	Deductible + 40%
Well-Child Care / Newborn Care	No cost to the member	40% Coinsurance
Mammogram	No cost to the member	Deductible + 40%
This is not intended to be an all-inclusive list. Preventive Health Services are defined in the Patient Protection & Affordability Care Act and do not have any member cost sharing responsibility for In-Network services.		
PHYSICIAN SERVICES - When performed and billed in a physician's office		
MRIs and MRAs	**Deductible, then $50**	**Deductible + 40%**
Nuclear Stress Tests	**Deductible, then $50**	**Deductible + 40%**
INPATIENT HOSPITAL SERVICES		
Inpatient Hospital Services	Deductible	Deductible + 40%
Inpatient Rehabilitation Facility	Deductible	Deductible + 40%
Physician Services	Deductible	Deductible + 40%
MATERNITY SERVICES		
Physician Services - *one time copay per pregnancy (In-Network Only)*	**One time $250 copay**	**Deductible + 40%**
Inpatient Maternity Care	**Deductible**	**Deductible + 40%**
Radiology (ultrasound) for Maternity, when done outside physician office may result in additional member responsibility		
OUTPATIENT THERAPY SERVICES		
Cardiac Rehabilitation Therapy - *Limited to 30 visits annually*	Deductible, then $50	Deductible + 40%
Pulmonary Rehabilitation Therapy - *Limited to 30 visits annually*	Deductible, then $50	Deductible + 40%
Physical and Occupational Therapies - *Limited to 20 visits annually (combined)*	Deductible, then $50	Deductible + 40%
Speech Therapy - *Limited to 20 visits annually*	c	Deductible + 40%
CONVENIENCE CARE SERVICES		
Convenience Care Visit	**$35 copay**	**$35 copay**
URGENT AND EMERGENT CARE		
Urgent Care in an Urgent Care Facility	Deductible, then $75 Copay	**In-Network Deductible, then $75 Copay**
Emergency Services - *Copay is waived if admitted*	Deductible, then $150 Copay	
Ambulance	Deductible, then $150 Copay	
OUTPATIENT SERVICES - When performed and billed in an outpatient facility		
Advanced imaging including:		
– MRIs and MRAs	Deductible, then $50	Deductible + 40%
– CAT Scans	Deductible, then $50	Deductible + 40%
– PET Scans	Deductible, then $50	Deductible + 40%
– Nuclear Stress Tests	Deductible, then $50	Deductible + 40%
Ambulatory Surgery - *only facility claim; physician and ancillary providers may bill separately and thus could result in additional member responsibility*	**Deductible**	Deductible + 40%
Chemotherapy and Radiation Services	Deductible	Deductible + 40%
Dialysis	Deductible	Deductible + 40%
Family Planning	Deductible	Deductible + 40%
Laboratory Services - *When specimen is drawn in an outpatient facility*	Deductible	Deductible + 40%
Radiology - *When test is performed in an outpatient facility*	Deductible, then $50	Deductible + 40%
OTHER SERVICES		
Durable Medical Equipment (DME) - *Coinsurance does not apply to Out of-Pocket Maximum*	50%	50%
Orthotics - *Coinsurance does not apply to Out-of-Pocket Maximum*	50%	50%
Prosthetics - *Coinsurance does not apply to Out-of-Pocket Maximum*	50%	50%
Home Health Care - *Limited to 120 visits annually*	Deductible	Deductible + 40%
Hospice	Deductible	Deductible + 40%
Skilled Nursing Facility - *Limited to 30 days annually*	Deductible	Deductible + 40%
Infertility Services - *Limited to $1,500 annual benefit maximum*	No Cost to the member	Deductible + 40%
PRESCRIPTION DRUG COPAYMENTS AFTER DEDUCTIBLE		
Deductible	$3,500	
Tier 1A - $3 / Tier 1 - $15 / Tier 2 - $35 / Tier 3 - $65 / Tier 4 - $100	SEE PAGE 6 FOR MORE DETAILS	

$5,000 PREMIER PLUS PLAN BENEFIT SUMMARY

BENEFITS	MEMBER PAYS IN-NETWORK	MEMBER PAYS OUT-OF-NETWORK
ANNUAL DEDUCTIBLE	Individual: $5,000 Family: $15,000	Individual: $5,000 Family: $15,000
ANNUAL OUT-OF-POCKET MAXIMUM	Individual: NA Family: NA	Individual: $3,000 Family: $9,000
PRIMARY CARE PHYSICIAN (PCP) SERVICES - When performed and billed in a physician's office.		
Office Visits	$30 Copay	Deductible + 30%
Allergy Testing, Treatment and Injections	$30 Copay	Deductible + 30%
Chemotherapy and Radiation	$30 Copay	Deductible + 30%
Family Planning	$30 Copay	Deductible + 30%
Laboratory Services - *When specimen is drawn in physician's office*	$30 Copay	Deductible + 30%
Radiology - *When test is performed in physician's office*	$30 Copay	Deductible + 30%
Physician services are limited to one Copay per Member, per provider, per date of service and per place of service. Copay applies to every visit to the office		
SPECIALIST PHYSICIAN SERVICES - When performed and billed in a physician's office.		
Office Visits	$60 Copay	Deductible + 30%
Allergy Testing, Treatment and Injections	$60 Copay	Deductible + 30%
Chemotherapy and Radiation	$60 Copay	Deductible + 30%
Family Planning	$60 Copay	Deductible + 30%
Laboratory Services - *When specimen is drawn in physician's office*	$60 Copay	Deductible + 30%
Radiology - *When test is performed in physician's office*	$60 Copay	Deductible + 30%
Physician services are limited to one Copay per Member, per provider, per date of service and per place of service. Copay applies to every visit to the office		
PREVENTIVE HEALTH SERVICES		
Annual Adult Physical	No cost to the member	Deductible + 30%
Annual Well-Woman exam (*including annual Pap smear*)	No cost to the member	Deductible + 30%
Immunizations and Vaccines	No cost to the member	Deductible + 30%
Well-Child Care / Newborn Care	No cost to the member	30% Coinsurance
Mammogram	No cost to the member	Deductible + 30%
This is not intended to be an all-inclusive list. Preventive Health Services are defined in the Patient Protection & Affordability Care Act and do not have any member cost sharing responsibility for In-Network serv		
PHYSICIAN SERVICES - When performed and billed in a physician's office		
MRIs and MRAs	$100 Copay + Deductible	Deductible + 30%
Nuclear Stress Tests	$100 Copay + Deductible	Deductible + 30%
INPATIENT HOSPITAL SERVICES		
Inpatient Hospital Services	Deductible	Deductible + 30%
Inpatient Rehabilitation Facility	Deductible	Deductible + 30%
Physician Services	Deductible	Deductible + 30%
MATERNITY SERVICES		
Physician Services - *one time copay per pregnancy (In-Network Only)*	One time $60 copay	Deductible + 30%
Inpatient Maternity Care	Deductible	Deductible + 30%
Radiology (ultrasound) for Maternity, when done outside physician office may result in additional member responsibility		
OUTPATIENT THERAPY SERVICES		
Cardiac Rehabilitation Therapy - *Limited to 30 visits annually*	$60 Copay	Deductible + 30%
Pulmonary Rehabilitation Therapy - *Limited to 30 visits annually*	$60 Copay	Deductible + 30%
Physical and Occupational Therapies - *Limited to 20 visits annually (combined)*	$60 Copay	Deductible + 30%
Speech Therapy - *Limited to 20 visits annually*	$60 Copay	Deductible + 30%
CONVENIENCE CARE SERVICES		
Convenience Care Visit	$30 copay	$30 copay
URGENT AND EMERGENT CARE		
Urgent Care in an Urgent Care Facility	$75 Copay	$75 Copay
Emergency Services - *Copay is waived if admitted*	$200 Copay	$200 Copay
Ambulance	$200 Copay	$200 Copay
OUTPATIENT SERVICES - When performed and billed in an outpatient facility		
Advanced imaging including:		
– MRIs and MRAs	$100 Copay + Deductible	Deductible + 30%
– CAT Scans	$100 Copay + Deductible	Deductible + 30%
– PET Scans	$100 Copay + Deductible	Deductible + 30%
– Nuclear Stress Tests	$100 Copay + Deductible	Deductible + 30%
Ambulatory Surgery - *only facility claim; physician and ancillary providers may bill separately and thus could result in additional member responsibility*	$100 Copay + Deductible	Deductible + 30%
Chemotherapy and Radiation Services	Deductible	Deductible + 30%
Dialysis	Deductible	Deductible + 30%
Family Planning	Deductible	Deductible + 30%
Laboratory Services - *When specimen is drawn in an outpatient facility*	Deductible	Deductible + 30%
Radiology - *When test is performed in an outpatient facility*	Deductible	Deductible + 30%
OTHER SERVICES		
Durable Medical Equipment (DME) - *Coinsurance does not apply to Out of-Pocket Maximum*	50%	50%
Orthotics - *Coinsurance does not apply to Out-of-Pocket Maximum*	50%	50%
Prosthetics - *Coinsurance does not apply to Out-of-Pocket Maximum*	50%	50%
Home Health Care - *Limited to 120 visits annually*	Deductible	Deductible + 30%
Hospice	Deductible	Deductible + 30%
Skilled Nursing Facility - *Limited to 30 days annually*	Deductible	Deductible + 30%
Infertility Services - *Limited to $1,500 annual benefit maximum*	No Cost to the member	Deductible + 30%
PRESCRIPTION DRUG COPAYMENTS		
Tier 1A - $3 / Tier 1 - $15 / Tier 2 - $35 / Tier 3 - $65 / **Tier 4 - $100**	SEE PAGE 6 FOR MORE DETAILS	

PRESCRIPTION DRUG RIDER

COVENTRY

$3,500 CHOICE PLAN

PLAN DEDUCTIBLE REQUIREMENTS: You must pay the Plan Deductible each Benefit Year before You may receive Coverage for:

- Tier 2 Prescription Drugs
- Tier 3 Prescription Drugs
- Tier 4 Prescription Drugs

COPAYMENTS: Before copayments for Tiers 2, 3, and 4 apply you must pay the Medical Plan Deductible, the Your Copayment for up to a 31 day supply of Prescription Drugs *other than* Self-Administered Injectable Drugs and Specialty Pharmacy Drugs is:

- $3 for Tier 1A Prescription Drugs - Deductible requirements do not apply
- $15 for Tier 1 Prescription Drugs - Deductible requirements do not apply
- $35 for Tier 2 Prescription Drugs
- $65 for Tier 3 Prescription Drugs

After You have satisfied Your Health Plan Deductible as noted above, Your Copayment for Self-Administered Injectable Drugs and Specialty Pharmacy Drugs is:

- $100 Copay

Prescription Drugs on the Mail Order Drug List may be dispensed with the applicable Mail Order copayment for a 93 day supply. After you have satisfied Your Health Plan Deductible as noted above, Your Mail Order Copayment for a ninety-three (93) day supply of Prescription Drugs is:

- 2x the copayment for Tier 1 or Tier 1A Prescription Drugs
- 2.5x the copayment for Tier 2 Prescription Drugs
- 3x the copayment for Tier 3 Prescription Drugs
- Mail order is not available for Tier 4 Prescription Drugs and Specialty Medications

$5,000 PREMIER PLUS PLAN

COPAYMENTS: Your Copayment for up to a thirty-one (31) day supply of Prescription Drugs *other than* Self-Administered Injectable Drugs is:

- $3 for Tier 1A Prescription Drugs
- $15 for Tier 1 Prescription Drugs
- $35 for Tier 2 Prescription Drugs
- $65 for Tier 3 Prescription Drugs

Your Coinsurance for Self-Administered Injectable or Specialty Pharmacy Tier 4 Prescription Drugs is:

- 10% Coinsurance, up to a $2,500 Annual Out-of-Pocket Rider maximum

Prescription Drugs on the Mail Order Drug List may be dispensed with the applicable Mail Order Copayment for a 93 day supply. Your Mail Order Copayment for a ninety-three (93) day supply of Prescription Drugs is:

- 2x the copayment for Tier 1 or Tier 1A Prescription Drugs
- 2.5x the copayment for Tier 2 Prescription Drugs
- 3x the copayment for Tier 3 Prescription Drugs
- Mail order is not available for Tier 4 Prescription Drugs or Specialty Medications

ADDITIONAL PRESCRIPTION DRUG BENEFIT INFORMATION FOR BOTH PLANS

- The mail order Prescription Drug benefit is available through a mail order pharmacy designated by the Health Plan and/or certain Participating retail pharmacies. Prescription Drugs on the Mail Order Drug List may be dispensed with the applicable Mail Order Copayment for a ninety-three (93) day supply. Please note that not all Participating pharmacies provide this benefit. Please call Customer Service at 1-800-395-2545 for information on mail order pharmacies.
- Specialty Medications will only be available through Specialty Providers designated by the Health Plan.
- If a Tier 2 Prescription Drug is dispensed, and a Therapeutically Equivalent Tier 1 or Tier 1A Prescription Drug is available, You must pay the Tier 3 Prescription Drug Copayment.
- If a Tier 3 Prescription Drug is dispensed and a Therapeutically Equivalent Tier 1 or Tier 1A Prescription Drug is available You must pay the Tier 3 Prescription Drug Copayment.
- Coverage is subject to drug utilization guidelines including quantity limits and/or prior authorization. If a drug requires prior authorization or exceeds a specific quantity limit, the prescribing provider must contact the health plan *before* a prescription is filled or refilled.
- Payment for covered Prescription Drugs is limited to the contracted amount the Health Plan would normally pay, less the Member's applicable Copayment and/or Deductible.
- Payments you make for covered benefits under this rider do not count toward the deductible or out-of-pocket maximum under the health plan.
- You have the right to appeal any decision made by the health plan. You may obtain information on how to file an appeal by visiting our website at www.chcga.com or calling customer service at 1-800-395-2545.

COVENTRY

VISION CARE RIDER - INCLUDED WITH MEDICAL

This Vision Care Rider is an attachment to the Coventry Health Care of Georgia, Inc. ("Health Plan") Certificate of Coverage.

The Health Plan has contracted with specific Vision Network Providers for the provision of the routine vision care services covered under this Rider. **You must receive the services covered under this Rider from a Vision Network Provider. Vision care services provided by non-Vision Network Providers and Non-Participating Providers and *not* covered.** [The Health Plan's current Vision Network Provider is Avesis, Inc.

Members Must Use an Avesis Vision Network Provider for Routine Vision Exams.
To obtain a list of Avesis Vision Network Providers:
Please visit our website at www.chcga.com
or call Customer Service at 1-800-395-2545

SECTION 1 - COVERED SERVICES

Subject to the limitations, exclusions Copayments and terms described herein, the following vision care benefits will be provided:

A. **Eye Examination.** An eye examination and refraction provided by a Vision Network Provider is covered under this Rider. Eye examinations include, at the Vision Network Provider's discretion and if Medically Necessary:

B. **Eyeglasses and Contact Lenses Benefits.** You are allowed a monetary allowance to be used toward the costs of standard eyeglasses and/or contact lenses as noted in the following chart. The Vision Network Provider shall apply this allowance toward the costs of eyeglasses (including lenses, frames or installation of lenses) or contact lenses (including lenses, fitting and follow-up care). You are responsible to pay for any costs relating to this benefit in excess of such allowance.

(a) medical history
(b) evaluation of visual acuity
(c) external examination of the eye
(d) binocular measure
(e) ophthalmoscopic examination
(f) medication for dilating pupils and desensitizing the eyes for tonometry
(g) summary and findings
(h) a determination as to the need for correction of visual acuity
(i) prescribing lenses if needed
(j) confirming the appropriateness of eyeglasses or contact lenses obtained under the prescription

Benefits Covered	Member Pays	Frequency of Benefit
Eye Examination	$15	1 exam every 12 months
Eyeglasses and/or Contact Lenses	You receive a $100 Hardware Allowance at the time of purchase (Vision Network Provider subtracts $100 from Your total hardware bill)	$100 allowance every 12 months

SECTION 2 - LIMITATIONS AND EXCLUSIONS

A. **Limitations.** The benefits under this Rider may not be combined with any sale, special offer or promotional pricing.

Payments you make for covered services under this Rider will not be applied to the Deductible or Out-of-Pocket Maximu under you health plan.

B. **Exclusions.** The following are not covered under this Rider:

(a) Materials required by an employer as a condition of employment;
(b) Materials provided as a result of any workers compensation law or similar legislation;
(c) Any material obtained through, or required by, a governmental agency;
(d) Drugs or other medications not administered for the purpose of the vision examination;
(e) Special or unusual procedures, such as but not limited to, orthoptics, vision training, subnormal vision aids, rehabilitative services, tonography, or services which are experimental in nature;
(f) Cosmetic eye surgery, which includes any surgery for the improvement of appearance rather than the correction c
(g) vision; and
Services provided by Non-Vision Network Providers and Non-Participating Providers, except in an emergency, as determined solely by the Health Plan.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

Our Health Reimbursement Arrangement (HRA) administrator is MedCom out of Jacksonville, Florida. Each employee enrolled in a medical plan will automatically be enrolled in our HRA. Money in the account will only be allowed for the following reimbursements:

$3,500 Choice Plan - The HRA will reimburse the last $1,000 of the calendar year deductible.
$5,000 Premier Plus Plan - The HRA will reimburse the last $2,500 of the calendar year deductible

HOW DOES THE HRA WORK?

The calendar year deductible for the Choice Plan is $3,500 and $5,000 on the Premier Plus Plan. To assist employees who meet this deductible, the City is funding a Health Reimbursement Arrangement (HRA) that will reimburse each person the last portion of their deductible ($1,000 for the Choice Plan and $2,500 on the Premier Plus Plan) IF you have a claim. This means your *NET DEDUCTIBLE* will be $2,500 per year on either plan.

If you cover family members on your medical plan the HRA will reimburse the last portion of their deductibles as well.

WHAT EXPENSES ARE COVERED UNDER AN HRA?

- City of Locust Grove will reimburse the last **$1,000 of your** insurance deductible on the **$3,500 Choice Plan** and **$2,500** on the **$5,000 Premier Plus Plan** (this makes your net deductible $2,500 on both plans).

HOW ARE EXPENSES REIMBURSED?

In order to receive payment, you must send a completed Reimbursement Form and Explanation of Benefits (EOB) to MedCom in one of the following ways:

- A completed Reimbursement Form and EOB can be **mailed** to:
  MedCom Flex Dept
  P.O. Box 10269
  Jacksonville, FL 32247-0269
  Telephone: 800-523-7542 Option 1
- A claim may be filed via **e-mail** and sent to MedcomReceipts@emedcom.net, you can scan the Reimbursement Form and EOB.
- You can **fax** the Reimbursement Form and EOB to:
  Fax: 866-598-7800
- You can submit **online** at
  www.mywealthcareonline.com/medcom

Once the claim has been processed a check will be issued and mailed directly to the participant.

WHAT IS AN EOB?

An Explanation of Benefits (EOB) is a form or document that is sent to you by Coventry after you had a healthcare service that was paid by the insurance company. Your EOB gives you information about how an insurance claim from a health provider (such as a doctor or hospital) was paid on your behalf. An EOB has the following information: Name of patient who received service, Claim Number, Provider, Type of Service, Date of Service, the amount of payment actually made to your provider and how much of your annual deductible has been met. The EOB is required in order for you to receive reimbursement from the HRA.

WHERE DO I FIND A REIMBURSEMENT FORM?

There is a reimbursement form included in your open enrollment packet. You may request additional forms from MSI Benefits Group, Inc. by calling 800-580-1629, by visiting http://www.emedcom.net/forms/CLAIM_FORM.pdf or by visiting your Human Resources Department.

ONLINE ACCOUNT ACCESS

Active participants may track their HRA account status online. Simply log onto www.emedcom.net, and click on "Employee Login" to create your account.

RUNOUT PERIOD (TIMELY FILING)

All claim forms must be submitted, in order to be considered for reimbursement for 2013 services, by March 31, 2014. If a claim form is submitted after this deadline it will be denied due to timely filing.

Sun Life Financial

DENTAL BENEFIT SUMMARY

GENERAL INFORMATION	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible (Deductible is waived for Type I and Type IV)	**$50 Individual $150 Family**	
Calendar Year Maximum	**$1,500 per person**	**$1,500 per person**
Type I - Preventive Procedures such as oral exams, cleanings, sealants, and fluoride treatment - also includes problem focused exams	**100% of fee schedule**	**100% of usual and customary**
Type II - Basic Procedures such as amalgam and composite restorations, simple extractions, space maintainers, oral surgery, and general anesthesia. - also includes endodontics - also includes periodontics - also includes surgical periodontics - also includes non-surgical periodontics	**80% of fee schedule**	**80% of usual and customary**
Type III - Major Procedures such as crowns and dentures	**50% of fee schedule**	**50% of usual and customary**
Type IV - Orthodontic Procedures for child(ren) under age 19 only	**50% of fee schedule**	**50% of usual and customary**

To find a provider, or with questions on your dental coverage, call 888-222-3660, Monday through Friday, 8 a.m. to 8 p.m. E.T. You can also visit www.sunlifedentalbenefits.com.

EMPLOYEE DEDUCTIONS

Bi-Weekly (26 / year)

MEMBERS COVERED	Employee Cost
Employee Only	$0.00
Employee + Spouse	$0.00
Employee + Child(ren)	$0.00
Employee + Family	$0.00

The City of Locust Grove pays 100% of the cost for this benefit.

This summary represents a general overview and is not a complete description of your plan. It is being provided before the issuance of the certificate. All of our dental policies include exclusions, limitations, and frequency requirements. The actual provisions of your dental policy will be used to determine coverage for any claims submitted to us.

For complete plan details

This summary is intended to provide an overview of the benefits available from your employer and is not intended to be a complete description of plan provisions. Receipt of this flyer does not certify eligibility for benefits under this plan. Your employer will have available the Sun Life Financial Group Dental certificate containing complete plan details.

BASIC TERM LIFE and AD&D INSURANCE

Sun Life Financia

The death of a family provider can mean that a family will not only find itself facing the loss of a loved one, but also the loss of financial security. With our Group Term Life Plan, employees can achieve peace of mind by giving their family the security they can depend upon.

ELIGIBILITY

Coverage for all full-time employees.

BENEFIT AMOUNT

Basic Group Term Life Insurance is equal to **$50,000**

AGE REDUCTION

Benefits are reduced to 65% at age 65 and 50% at age 70. Coverage is discontinued at termination of employment or retirement.

ACCIDENTAL DEATH and DISMEMBERMENT (AD&D)

AD&D insurance which could pay an additional benefit, up to the amount of your Life benefit, if you suffer a covered loss due to an accident

ACCELERATED BENEFITS

Accelerated benefits help offset expenses at a critical time. You may collect a portion of your benefits during your lifetime if you become terminally ill.

PORTABILITY

When coverage ends for reasons other than sickness, injury, retirement, or termination of the employer's plan, employees can apply for a portable Term Life policy without Evidence of Insurability.

POLICHOLDER CONTRIBUTION

The City of Locust Grove pays 100% of the cost for this coverage.

HOW TO ENROLL

Basic group term life coverage begins automatically when you meet the eligibility requirements. You'll need to designate beneficiaries for your basic life benefits using a group enrollment form.

FOR COMPLETE PLAN DETAILS

This highlight flyer is intended to provide an overview of the benefits available from the City of Locust Grove and is not a complete description of plan provisions. Receipt of this flyer does not certify eligibility for benefits under this plan. The Sun Life Financial Group booklet containing complete plan details will be available in the Human Resources Department.

Sun Life Financial

GROUP SHORT TERM DISABILITY

Short Term Disability (STD) helps protect the financial health of you and your family should you ever suffer a disability that prevents you from working for months or even years. We focus on returning disabled employees to productive work whenever possible.

This page highlights the benefits available through your employer. For more information see the Sun Life Assurance Company of Canada Group STD booklet available from your employer.

ELIGIBILITY

Coverage for all full-time employees working 30 or more hours per week.

STD BENEFIT AMOUNT

60% of your weekly salary up to a maximum of $1,000 per week for covered accident and sickness.

ELIMINATION PERIOD

Benefits begin on the **8th day** absent for covered accidents and on the **8th day** for covered sickness.

MAXIMUM BENEFIT DURATION

25 Weeks

POLICHOLDER CONTRIBUTION

The City of Locust Grove pays 100% of the cost for this coverage.

HOW TO ENROLL

Short Term Disability coverage begins automatically when you meet the eligibility requirements and satisfy the waiting period.

DISABILITY CAN HAPPEN TO ANYONE

Want to know more about your chances of becoming disabled? Sun Life Financial is a founding member of the Council for Disability Awareness. Visit www.disabilitycanhappen.org and find out your Personal Disability Quotient.

FOR COMPLETE PLAN DETAILS

This highlight flyer is intended to provide an overview of the benefits available from the City of Locust Grove and is not a complete description of plan provisions. Receipt of this flyer does not certify eligibility for benefits under this plan. The Sun Life Financial Group booklet containing complete plan details will be available in the Human Resources Department.

GROUP LONG TERM DISABILITY

Sun Life Financia

Long Term Disability (LTD) helps protect the financial health of you and your family should you ever suffer a disability that prevents you from working for months or even years. We focus on returning disabled employees to productive work whenever possible.

This page highlights the benefits available through your employer. For more information see the Sun Life Assurance Company of Canada Group LTD booklet available from your employer.

ELIGIBILITY

Coverage for all full-time employees working 30 or more hours per week.

LTD BENEFIT AMOUNT

60% of your monthly pay up to a maximum of $4,000 per month for covered accident and sickness.

ELIMINATION PERIOD

Benefits begin after you have been absent from work for **180 days** of absences due to a covered accident of sickness.

MAXIMUM BENEFIT DURATION

Social Security Normal Retirement Age (SSNRA)

POLICHOLDER CONTRIBUTION

The City of Locust Grove pays 100% of the cost for this coverage.

HOW TO ENROLL

Long Term Disability coverage begins automatically when you meet the eligibility requirements.

DISABILITY CAN HAPPEN TO ANYONE

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FOR COMPLETE PLAN DETAILS

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Sun Life Financial

VOLUNTARY TERM LIFE and AD&D INSURANCE

ELIGIBLE EMPLOYEES

All full-time employees working in the United States enrolled in the Basic Life Insurance who are scheduled to work a minimum of 30 hours per week.

BENEFIT AMOUNT

For you: An amount between $10,000 and $300,000, in increments of $10,000, not to exceed 5x basic annual earnings. Benefits cease at retirement.

For your spouse: An amount between $5,000 and $150,000 in increments of $5,000. Spouse voluntary life coverage may not exceed 50% of the employee's coverage. Coverage ends when you spouse turns 70.

For your dependent child(ren): $10,000. Child voluntary life coverage may not exceed 50% of the employee's coverage. Eligible children include unmarried children from 14 days to age 19 or to age 24 if a full-time student.

You must elect voluntary life insurance on yourself in order to cover your spouse and/or children.

AGE REDUCTION

Employee: All coverage amounts reduce to 65% at age 65, 50% at age 70.
Spouse: None
Child(ren): None

GUARANTEED ISSUE (GI) AMOUNTS

GI is the amount of life insurance available to you without Evidence of Insurability (medical questions). GI is only available during your initial eligibility period.

Employee: **$100,000**
Spouse: **$ 25,000**
Child: **$ 10,000**

ACCIDENTAL DEATH and DISMEMBERMENT (AD&D)

Protection for covered Accidental Death and covered injuries such as speech/hearing, loss of limb, loss of use of a limb due to quadriplegia, paraplegia, or hemiplegia, and thumb and index finger. AD&D cost is included in the rates on the following page.

WAIVER OF PREMIUM

Waiver benefits protect employees who are totally disabled, as defined by the policy.

PORTABILITY

When coverage ends for reasons other than sickness, injury, retirement, or termination of the employer's plan, employees can apply for a portable Term Life policy without Evidence of Insurability.

FOR COMPLETE PLAN DETAILS

This highlight flyer is intended to provide an overview of the benefits available from the City of Locu Grove and is not a complete description of plan provisions. Receipt of this flyer does not certify eligibility for benefits under this plan. The Sun Life Financial Group booklet containing complete pla details will be available in the Human Resources Department.

VOLUNTARY TERM LIFE and AD&D INSURANCE

Sun Life Financial

EMPLOYEE VOLUNTARY TERM LIFE and AD&D INSURANCE - BI-WEEKLY DEDUCTIONS												
AGE	< 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$10,000	$0.46	$0.51	$0.55	$0.60	$0.92	$1.38	$2.35	$3.92	$5.40	$9.41	$19.33	$29.58
$20,000	$0.92	$1.02	$1.11	$1.21	$1.85	$2.77	$4.71	$7.85	$10.81	$18.82	$38.67	$59.17
$30,000	$1.38	$1.54	$1.66	$1.81	$2.77	$4.15	$7.06	$11.77	$16.21	$28.23	$58.00	$88.75
$40,000	$1.85	$2.05	$2.22	$2.42	$3.69	$5.54	$9.42	$15.69	$21.62	$37.64	$77.34	$118.34
$50,000	$2.31	$2.56	$2.77	$3.02	$4.62	$6.92	$11.77	$19.62	$27.02	$47.05	$96.67	$147.92
$60,000	$2.77	$3.07	$3.32	$3.63	$5.54	$8.31	$14.12	$23.54	$32.43	$56.46	$116.00	$177.51
$70,000	$3.23	$3.59	$3.88	$4.23	$6.46	$9.69	$16.48	$27.46	$37.83	$65.88	$135.34	$207.09
$80,000	$3.69	$4.10	$4.43	$4.84	$7.38	$11.08	$18.83	$31.38	$43.24	$75.29	$154.67	$236.68
$90,000	$4.15	$4.61	$4.98	$5.44	$8.31	$12.46	$21.18	$35.31	$48.64	$84.70	$174.00	$266.26
$100,000	$4.62	$5.12	$5.54	$6.05	$9.23	$13.85	$23.54	$39.23	$54.05	$94.11	$193.34	$295.85
$110,000	$5.08	$5.64	$6.09	$6.65	$10.15	$15.23	$25.89	$43.15	$59.45	$103.52	$212.67	$325.43
$120,000	$5.54	$6.15	$6.65	$7.26	$11.08	$16.62	$28.25	$47.08	$64.86	$112.93	$232.01	$355.02
$130,000	$6.00	$6.66	$7.20	$7.86	$12.00	$18.00	$30.60	$51.00	$70.26	$122.34	$251.34	$384.60
$140,000	$6.46	$7.17	$7.75	$8.46	$12.92	$19.38	$32.95	$54.92	$75.66	$131.75	$270.67	$414.18
$150,000	$6.92	$7.68	$8.31	$9.07	$13.85	$20.77	$35.31	$58.85	$81.07	$141.16	$290.01	$443.77
$200,000	$9.23	$10.25	$11.08	$12.09	$18.46	$27.69	$47.08	$78.46	$108.09	$188.22	$386.68	$591.69
$250,000	$11.54	$12.81	$13.85	$15.12	$23.08	$34.62	$58.85	$98.08	$135.12	$235.27	$483.35	$739.62
$300,000	$13.85	$15.37	$16.62	$18.14	$27.69	$41.54	$70.62	$117.69	$162.14	$282.32	$580.02	$887.54

SPOUSE VOLUNTARY TERM LIFE and AD&D INSURANCE - BI-WEEKLY DEDUCTIONS										
AGE	< 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69
$5,000	$0.23	$0.26	$0.28	$0.30	$0.46	$0.69	$1.18	$1.96	$2.70	$4.71
$10,000	$0.46	$0.51	$0.55	$0.60	$0.92	$1.38	$2.35	$3.92	$5.40	$9.41
$15,000	$0.69	$0.77	$0.83	$0.91	$1.38	$2.08	$3.53	$5.88	$8.11	$14.12
$20,000	$0.92	$1.02	$1.11	$1.21	$1.85	$2.77	$4.71	$7.85	$10.81	$18.82
$25,000	$1.15	$1.28	$1.38	$1.51	$2.31	$3.46	$5.88	$9.81	$13.51	$23.53
$30,000	$1.38	$1.54	$1.66	$1.81	$2.77	$4.15	$7.06	$11.77	$16.21	$28.23
$35,000	$1.62	$1.79	$1.94	$2.12	$3.23	$4.85	$8.24	$13.73	$18.92	$32.94
$40,000	$1.85	$2.05	$2.22	$2.42	$3.69	$5.54	$9.42	$15.69	$21.62	$37.64
$45,000	$2.08	$2.31	$2.49	$2.72	$4.15	$6.23	$10.59	$17.65	$24.32	$42.35
$50,000	$2.31	$2.56	$2.77	$3.02	$4.62	$6.92	$11.77	$19.62	$27.02	$47.05
$55,000	$2.54	$2.82	$3.05	$3.33	$5.08	$7.62	$12.95	$21.58	$29.73	$51.76
$60,000	$2.77	$3.07	$3.32	$3.63	$5.54	$8.31	$14.12	$23.54	$32.43	$56.46
$65,000	$3.00	$3.33	$3.60	$3.93	$6.00	$9.00	$15.30	$25.50	$35.13	$61.17
$70,000	$3.23	$3.59	$3.88	$4.23	$6.46	$9.69	$16.48	$27.46	$37.83	$65.88
$75,000	$3.46	$3.84	$4.15	$4.53	$6.92	$10.38	$17.65	$29.42	$40.53	$70.58
$100,000	$4.62	$5.12	$5.54	$6.05	$9.23	$13.85	$23.54	$39.23	$54.05	$94.11
$125,000	$5.77	$6.40	$6.92	$7.56	$11.54	$17.31	$29.42	$49.04	$67.56	$117.63
$150,000	$6.92	$7.68	$8.31	$9.07	$13.85	$20.77	$35.31	$58.85	$81.07	$141.16

DEPENDENT CHILD(REN) VOLUNTARY TERM LIFE and AD&D INSURANCE - BI-WEEKLY DEDUCTIONS
$10,000 Life and AD&D Insurance $1.06

CONTINUATION COVERAGE RIGHTS UNDER COBRA

CITY of LOCUST GROVE HEALTH PLAN

Introduction
You are receiving this notice because you have recently become eligible for the City of Locust Grove health plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child"

When is COBRA Coverage Available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events
For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice **in writing** to: **Theresa Breedlove, City of Locust Grove P.O. Box 900, Locust Grove, GA 30248.**

CONTINUATION COVERAGE RIGHTS UNDER COBRA

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Information about the plan and COBRA continuation coverage can be obtained on request from:

Theresa Breedlove
City of Locust Grove
P.O. Box 900
Locust Grove, GA 30248
Phone: 770-957-5043

BENEFIT ELECTIONS and COSTS

You may use this form to record your benefit elections and costs.

Type of Benefit	Benefit Plan	Coverage Level / Coverage Amount	Deductic Amoun
Medical			
Dental	100% Employer Paid		$0.(
Basic Life AD&D Insurance*	100% Employer Paid	$50,000	$0.(
Group Short Term Disability	100% Employer Paid		$0.
Group Long Term Disability	100% Employer Paid		$0.
Voluntary Life and AD&D Insurance*			
Voluntary Spousal Life and AD&D Insurance			
Voluntary Dependent Life and AD&D Insurance			
		Total Per Pay Cost:	
		Total Annual Cost:	

* **Reductions in Insurance:** Benefits are reduced to 65% at age 65 and to 50% at age 70. Coverage is discontinu at termination of employment or retirement.

IMPORTANT CONTACT INFORMATION

City of Locust Grove
Theresa Breedlove
City Clerk
Tel: 770-957-5043
tbreedlove@locustgrove-ga.gov

MEDICAL PLANS
Coventry Health Care of Georgia

Customer Service
Tel: 800-395-2545

Behavioral Health and Substance Abuse Services
Tel: 800-752-7242

Pharmacy Help Desk
Tel: 800-378-7040

www.chcga.com

MSI BENEFITS GROUP, INC.
Administrative Contact
Tel: 770-425-1231 / 800-580-1629
Fax: 770-425-6275 / 800-580-2675
www.msibenefitsgroup.com

DENTAL PLAN
Sun Life Financial
Customer Service
Tel: 888-222-3660
www.sunlifedentalbenefits.com

LIFE / DISABILITY INSURANCE
Sun Life Financial
Customer Service
Tel : 800-247-6875
www.sunlife-usa.com

This booklet is a summary only. Please refer to each plan's certificate of coverage / plan document for a complete description of all benefits and exclusions. If there is any difference between the information provided in this booklet and any certificate of coverage / plan document, the certificate of coverage / plan document will govern. Copies of all certificates of coverage / plan documents are available in the Human Resources department. In the event that some information changes, you will receive notice about the changes prior to the annual Open Enrollment. If you are a new employee, this information will help you to understand the benefit options available to you. If you're already covered by any of the benefit plans, you may refer to this booklet throughout the year as you use your benefits. This booklet also provides information regarding your COBRA rights and responsibilities.

MSI Benefits Group
245 TownPark Drive, Suite 100
Kennesaw, GA 30144
Tel: 770-425-1231 / 800-580-1629
Fax: 770-425-4722 / 800-580-2675
www.msibenefitsgroup.com

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